MDS 3.0: The Mini-series
Session #3

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February 2021

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MDS 3.0 – The Mini-series
Agenda

- Welcome
- Section G
- Section B
- Section C
- Section D
- Section E
- Section F
- Section K
- Section Q

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MDS 3.0 – The Mini-series Session #3

Questions from Session #2?

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MDS 3.0 – The Mini-series Section G

Section G - Functional Status

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

Section G will continue to be completed and used as the primary source to determine payment for long term care residents in Maine. The new item set will be implemented by CMS on 10/1/2023, at the earliest. This tentative date represents two full fiscal years after the Public Health Emergency ends.

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Section G

Section G - Payment Items for RUG III

G0110A1, 2 Bed mobility: Self-performance & support
G0110B1, 2 Transfer: Self-performance & support
G0110I 1, 2 Toileting: Self-performance & support
G0110H1 Eating: Self-performance Only

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Section G

Section G - G0110

1. **ADL Self-Performance**
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. **ADL Support Provided**
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	

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ADL Documentation handout for CNAs

Self performance Codes

0= **Independent: NO TALK, NO TOUCH**
Staff does no assist, instruct, nor cue: resident does All activity ALONE no monitoring, no hands on assistance. (with your eyes, you watched the resident thru the door)

1=**Supervised: TALK, NO TOUCH**
Staff provides instructions or cueing (verbal), but does not provide physical (hands on) assistance. Oversight and cueing staff uses mouth/voice only. NO HANDS


2= **Limited assistance: TALK and TOUCH**
Staff talks to give instructions or cues and touches resident to assist: can be as simple as putting hands on resident's back or holding his/her elbow while walking. Hands used for more than set up, but does not lift any part of the resident. The resident is highly involved, you did some hands on assist but it was NON-WEIGHT BEARING

3 = **Extensive assistance: TALK, TOUCH, and LIFT**
Staff uses muscle power to lift, move, or "shift" resident. This includes lifting legs into bed, "scooting" buttocks into positioning in bed, lifting arm to assist in self feeding. The resident performed part of the activity, but WEIGHTBEARING ASSIST (someone lifted a part of the body) was required.

4 = **Total Dependence: ALL ACTION BY STAFF**
Resident dose not participate at all in any part of the activity being done for him/her. The resident didn't lift a finger to help

8 = **the activity didn't occur during the entire shift.**

IF THE STAFF MEMBER HAS TOUCHED THE RESIDENT AT ALL, CODE IS AT LEAST LIMITED ASSIST.

STAFF PERFORMANCE

0 = No staff performance required, zip, zero, nada.

1= set up help only, maybe you undid a cover, set the wheelchair at bedside or set out grooming items

2= ONE person. Physically assisted by one person

3 = 2 or more physically assisted.

8= Activity didn't occur during the whole shift.

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Section G: Self Performance

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all.
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

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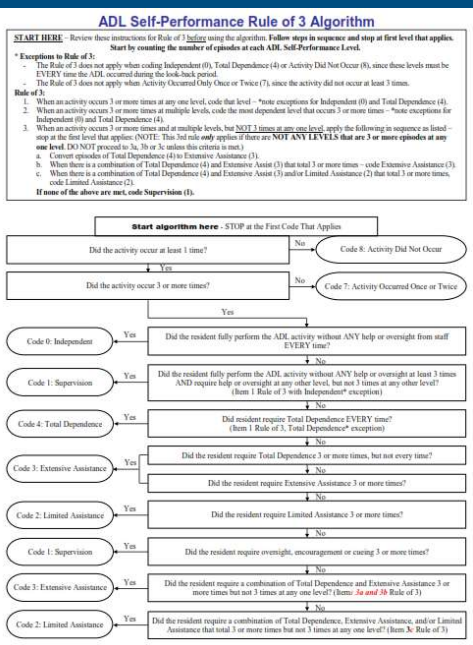

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Coding Tips

- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.

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Section G

- **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
- General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Code extensive assistance (1 or 2 persons):** If the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
- **Code totally dependent in eating:** Only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

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Section G

Coding activity did not occur, 8:

- **Toileting** would be **coded 8, activity did not occur**: Only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
- **Locomotion** would be **coded 8, activity did not occur**: If the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
- **Eating** would be **coded 8, activity did not occur**: If the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

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Coding Scenario

During the look-back period, Mr. S was able to toilet independently without assistance **18** times. The other **two** times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision. (RAI Manual, page G-23)

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Rationale: Toilet use occurred 20 times during the look-back period. Non-weight bearing assistance was provided two times and 18 times the resident used the toilet independently.

Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Mr. S did require assistance to complete the ADL two times; therefore, the Code 0 does not apply.

Code 7, Activity occurred only once or twice, did not apply because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times.

The assistance provided to the resident did not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period.

The ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either.

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The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice.

The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels.

The third Rule of 3 does not apply because the ADL occurred three or more times, at the independent level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items.

However, the final instruction to the provider is that when neither the Rule of 3 nor the ADL Self-Performance coding Level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use, the code Supervision (1) was entered.

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Section G

G0120: Bathing
- A. Self-Performance
- B. Support

G0300: Balance During Transitions and Walking

G0400: Functional Limitation in Range of Motion
- A. Upper Extremity
- B. Lower Extremity

G0600: Mobility Devices (check all that apply)

G0900: Functional Rehabilitation Potential

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Section G

Section G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking	
After observing the resident, **code the following walking and transition items for most dependent**	
	↓ Enter Codes in Boxes
Coding: 0. **Steady at all times** 1. **Not steady, but able to stabilize without staff assistance** 2. **Not steady, only able to stabilize with staff assistance** 8. **Activity did not occur**	☐ **A. Moving from seated to standing position** ☐ **B. Walking** (with assistive device if used) ☐ **C. Turning around** and facing the opposite direction while walking ☐ **D. Moving on and off toilet** ☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

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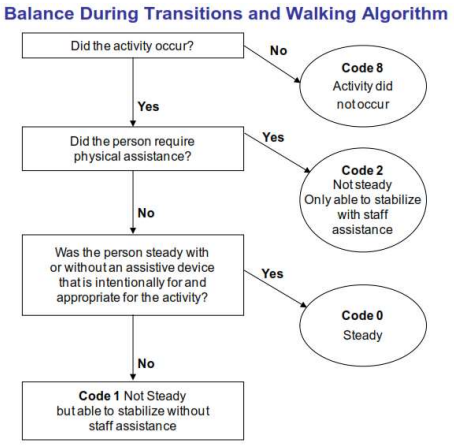
Section G

Section G0300: Balance During Transitions and Walking



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Section B

Section B
Hearing, Speech, and Vision

Intent: The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

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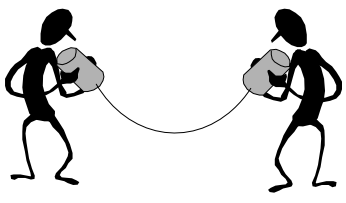
Section B

Section B

B0100: **Comatose**
B0200: Ability to Hear (with hearing aid if normally used)
B0300: Hearing Aid or hearing appliance
B0600: Speech Clarity
B0700: **Makes Self Understood**
B0800: Ability to Understand Others
B1000: Vision (with adequate light)
B1200: Corrective Lenses



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Section B

Section B

B0700, page B-7: 4. Consult with the primary nurse assistants (over all shifts), and the resident's family, and speech-language pathologist.

Coding Tips and Special Populations

- *This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews*, as the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make self understood during the entire 7-day look-back period.

- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.

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Section C

Section C: Cognitive Patterns

Intent: The items in this section are intended to determine the resident's attention, orientation, and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

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Section C

C0100: Should the Brief Interviews for Mental Status be Conducted?

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Code 0, **no**: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

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Section C

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted *during* the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted *within the look-back period (preferably the day before or the day of the ARD),* item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.
- Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS.

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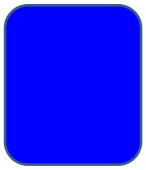
Section C

Section C

C0200-C0500: BIMS resident interview questions (scripted interview)

Sock



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Bed

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Section C

Section C

If the interview should be stopped, do the following:

1. Code **-, dash** in C0400A, C0400B, and C0400C.
2. Code **99** in the summary score in C0500.
3. Code **1, yes** in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
4. Complete the **Staff Assessment for Mental Status**.

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Section C

Section C

C0600: Should the *staff* assessment be conducted?

C0700: Short-Term Memory
C0800: Long-Term Memory
C0900: Memory/Recall Ability
C1000: Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

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Section C

C0700-C1000: Staff Assessment of Mental Status Item

Staff Assessment for Mental Status	
Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed	
C0700. Short-term Memory OK	
Enter Code ☐	**Seems or appears to recall after 5 minutes** 0. **Memory OK** 1. **Memory problem**
C0800. Long-term Memory OK	
Enter Code ☐	**Seems or appears to recall long past** 0. **Memory OK** 1. **Memory problem**
C0900. Memory/Recall Ability	
↓ **Check all that the resident was normally able to recall**	
☐	A. **Current season**
☐	B. **Location of own room**
☐	C. **Staff names and faces**
☐	D. **That he or she is in a nursing home/hospital swing bed**
☐	Z. **None of the above** were recalled
C1000. Cognitive Skills for Daily Decision Making	
Enter Code ☐	**Made decisions regarding tasks of daily life** 0. **Independent** - decisions consistent/reasonable 1. **Modified independence** - some difficulty in new situations only 2. **Moderately impaired** - decisions poor; cues/supervision required 3. **Severely impaired** - never/rarely made decisions

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Section C - C1310

DEFINITION

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

DEFINITION

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, or incoherent speech.

DEFINITIONS

INATTENTION
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look- back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.

DEFINITIONS

ALTERED LEVEL OF CONSCIOUSNESS
VIGILANT – startles easily to any sound or touch;
LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch;
STUPOR – very difficult to arouse and keep aroused for the interview;
COMATOSE – cannot be aroused despite shaking and shouting.

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MDS 3.0 – The Mini-series
Section C

C1310 Signs and Symptoms of Delirium

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐ **Is there evidence of an acute change in mental status** from the resident's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?

☐ **C. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered level of consciousness** - Did the resident have altered level of consciousness as indicated by any of the following criteria?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

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Section D

Section D: Mood

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

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Section D

Section D

D0100: Should Resident Mood Interview Be Conducted?

If yes…

D0200 (Resident Interview – PHQ9©)
Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for *timely completion* as documented at Z0400.

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Section D

Section D

Steps for Assessment

1. Interact with the resident using his or her preferred language. *Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.*
2. *Determine if the resident is rarely/never understood verbally, in writing, or using another method.*

Coding Instructions

Code 0, **no**: if the interview should not be *conducted* because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed, but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

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Section D

Section D

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

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Section D

Section D: D0200

D0200. Resident Mood Interview (PHQ-9©)			
Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*" Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*		CATs ☐	RUG III ☐ PDPM
B. *Feeling down, depressed, or hopeless*		☐	RUG III ☐ PDPM
C. *Trouble falling or staying asleep, or sleeping too much*		☐	RUG III ☐ PDPM
D. *Feeling tired or having little energy*		☐	RUG III ☐ PDPM
E. *Poor appetite or overeating*		☐	RUG III ☐ PDPM
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*		☐	RUG III ☐ PDPM
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		☐	RUG III ☐ PDPM
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*		☐	RUG III ☐ PDPM
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*		CATs ☐	RUG III ☐ PDPM

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Section D

Section D: D0300

D0300 Total Severity Score

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27, written as a two digit number, or "99" if symptom frequency is blank for 3 or more items.

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Section D

Section D: D0500

Staff Assessment of Resident Mood - PHQ-9-OV (observational version)

Look-back period for this item is 14 days.

- Interview staff from all shifts who know the resident best. (RAI Manual, page d-11)
- Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.

Supporting documentation is required.

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Section D

D0500. Staff Assessment of Resident Mood (PHQ-9-OV®)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	CATs	RUG III PDPM
B. Feeling or appearing down, depressed, or hopeless		RUG III PDPM
C. Trouble falling or staying asleep, or sleeping too much		RUG III PDPM
D. Feeling tired or having little energy		RUG III PDPM
E. Poor appetite or overeating		RUG III PDPM
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		RUG III PDPM
G. Trouble concentrating on things, such as reading the newspaper or watching television		RUG III PDPM
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		RUG III PDPM
I. States that life isn't worth living, wishes for death, or attempts to harm self	CATs	RUG III PDPM
J. Being short-tempered, easily annoyed		RUG III PDPM

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. CATs RUG III PDPM

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Section E

Section E: Behavior

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. This section focuses on the resident's actions, not the intent of his or her behavior. Staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent.

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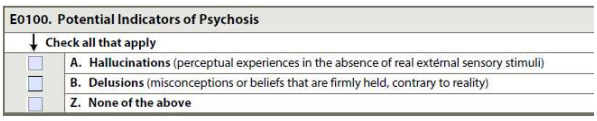
Section E

BEHAVIORAL SYMPTOMS

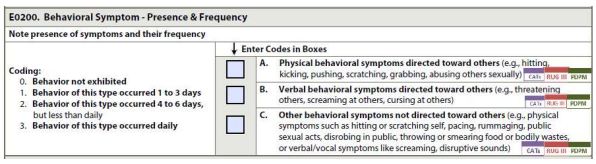
Payment Items

E0100A Hallucinations
E0100B Delusions



E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
☐	A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	Z. **None of the above**

E0200A Physical behaviors
E0200B Verbal behaviors
E0200C Other behaviors



E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		↓ Enter Codes in Boxes
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	☐	A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	☐	B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
	☐	C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

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MDS 3.0 – The Mini-series
Section E

Section E: E0200

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ **Enter Codes in Boxes**

A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) CATs RUG III PDPM

B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) CATs RUG III PDPM

C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) CATs RUG III PDPM

E0300: Overall Presence of Behavioral Symptoms
E0500: Impact on Resident
E0600: Impact on Others

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MDS 3.0 – The Mini-series
Section E

Section E: E0800 and E0900

E0800: Rejection of Care – Presence & Frequency

E0800. Rejection of Care - Presence & Frequency

Enter Code

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

CATs RUG III PDPM

E0900: Wandering – Presence & Frequency

E0900. Wandering - Presence & Frequency

Enter Code

Has the resident wandered?
0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

CATs RUG III PDPM

E1000: Wandering – Impact
E1000A Risk to Self
E1000B Intrusion on others
E1100: Change in Behavior or Other Symptoms

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Section F

Section F: Preferences for Customary Routine and Activities

Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities.

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MDS 3.0 – The Mini-series
Section F

Section F

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.

3. If resident is rarely/never understood and a family member or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.

Code 0 = no
Code 1 = yes

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Section K

Section K: Swallowing/Nutritional Status

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

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MDS 3.0 – The Mini-series
Section K

Section K: Weight Loss/Gain

K0100: Swallowing Disorder

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

K0200: Height and Weight

K0300: Weight Loss

K0310: Weight gain

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MDS 3.0 – The Mini-series
Section K

Section K - Nutritional Approaches

K0510: Approaches

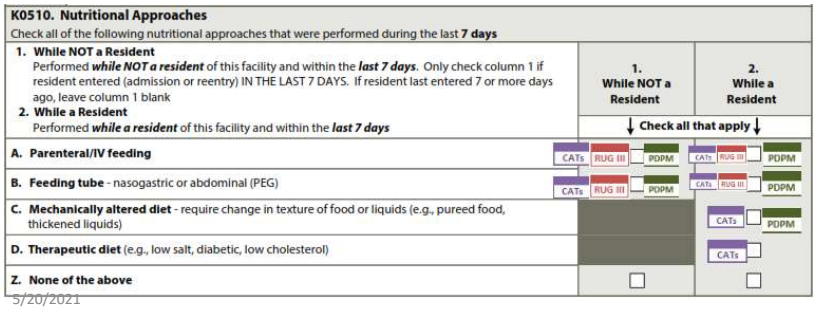
A. Parenteral / IV Feeding

B. Feeding Tube

C. Mechanically Altered Diet

D. Therapeutic Diet

Z. None of the above



K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

	1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	↓ Check all that apply ↓	
A. Parenteral/IV feeding	CATs RUG III PDPM	CATs RUG III PDPM
B. Feeding tube - nasogastric or abdominal (PEG)	CATs RUG III PDPM	CATs RUG III PDPM
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		CATs PDPM
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		CATs
Z. None of the above	☐	☐

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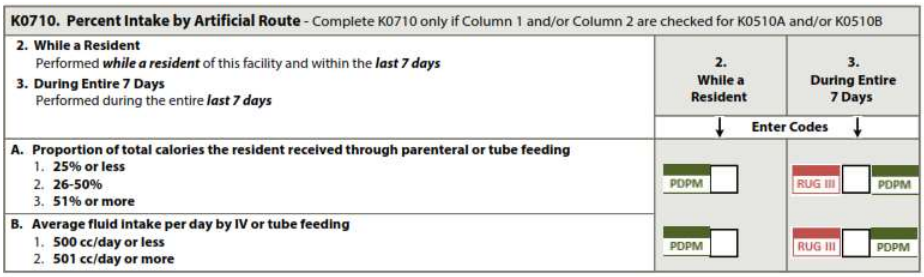
MDS 3.0 – The Mini-series
Section K



K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

	2. While a Resident	3. During Entire 7 Days
2. While a Resident Performed ***while a resident*** of this facility and within the ***last 7 days*** **3. During Entire 7 Days** Performed during the entire ***last 7 days***	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. **25% or less** 2. **26-50%** 3. **51% or more**	PDPM ☐	RUG III ☐ PDPM
B. Average fluid intake per day by IV or tube feeding 1. **500 cc/day or less** 2. **501 cc/day or more**	PDPM ☐	RUG III ☐ PDPM

If the resident took no food or fluids by mouth (NPO) or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, *consult with the dietician*.

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21 (c)(1)). This is also a civil right for all residents. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Q0100 Participation in Assessment:

Who participated??

Whenever possible, the resident should be actively involved, except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose.

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Q0300 Residents Overall Expectation
- Overall expectations
- Information source

Q0400 Discharge Plan

Q0490 Preference to Avoid Being Asked Question Q0500B

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Q0500B Return to Community

Q0500. Return to Community	
Enter Code ☐	B. **Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in talking to someone about the possibility of leaving the facility and returning to live and receive services in the community.

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)

Q0550B, what is the source of the information?

B. Indicate information source for Q0550A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family or significant other, then **guardian or legally authorized representative**
9. **None of the above**

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MDS 3.0 – The Mini-series
Section Q

Section Q - Participation in Assessment and Goal Setting

Q0600. Referral

Enter Code ☐

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)
0. **No** - referral not needed
1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)
2. **Yes** - referral made

Who is the Local Contact Agency for Maine?

Long-Term Care Ombudsman Program

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MDS 3.0 – The Mini-series Session #3

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Call the MDS Help Desk to register!

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MDS 3.0 – The Mini-series Session #3

Reminders!

- This completes *Session 3* of the MDS 3.0 training. Thank you for attending.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

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MDS 3.0 – The Mini-series Session #1

Contact Information:

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
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Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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Questions?

Sue Pinette RN, RAC-CT
Case Mix Manager, State RAI Coordinator
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